Treatment of Cancer of the Rectum.

In a clinical lecture at the Necker Hospital, Professor TRÉLAT drew the following conclusions with regard to the treatment of cancer of the rectum :—

1. Cancers of the rectum should not be touched, unless they cause grave disorders. This rule should be positive, with the single exception that very small cancerous deposits may be removed from the lower part of the rectum and the margin of the anus.

2. In all other cases the treatment should be confined to complications and palliative operations. In giving these rules I am in accord with Prof. Verneuil.

3. As palliative operations, rectotomy may be done when the finger can be passed beyond the upper limit of the neoplasm. If the neoplasm is more extensive, the surgeon should abandon rectotomy, and work out a way of derivation; for by performing rectotomy in these cases, the surgeon is almost certain to injure the peritoneum. With the English surgeons, and Labbé and Tillaux, I am in favour of lumbar colotomy, because it is a simple operation, less dangerous, and affords a ready means of exit for the feces. Other surgeons prefer to make an inguinal anus; but there is risk of opening the small intestine, with all the attendant dangers and inconveniences.—*Revue de Thérap.*, May 15, 1884.

Fractures of the Sternum and First Costal Cartilage.

At the meeting of the Pathological Society of London, on March 4th, 1884, Mr. ARBUTHNOT LANE read a paper on one way in which the sternum might be fractured. M. Maisonneuve had attributed fracture of the sternum to force transmitted from the shoulder to the sternum by the clavicle; whereas Mr. Rivington had contended that the action of the clavicle was in no way essential to fracture of the sternum, and regarded the first two ribs and cartilages as the means by which was transmitted to the sternum one of the forces which fractured or dislocated it, the other being conveyed along the lower ribs. He showed that, as the inner end of the clavicle was fixed by ligaments, if vertical pressure were applied to its outer extremity, a much greater force was exerted on the anterior extremity of the first rib by the shaft of the clavicle in contact. Mr. Lane next stated that the first cartilage was one inch and a half deep at its attachment to the manubrium, while the second cartilage was only five-eighths of an inch; so that, when one cartilage was depressed by the clavicle, it tended to cause the manubrium to rotate around an antero-posterior axis, and also affected the opposite cartilage. If the pressure exerted were very great, one or both first costal cartilages might be broken, together with the sternum, without there being any displacement of fragments. Or only one cartilage might be broken. If the cartilages were very elastic, and the sternum rigid, it alone might yield, as in an experiment he had made on the dead body. In this case, the manubrium was ossified to the gladiolus. A heavy blow was struck on the outer extremity of the clavicle (carefully padded, in order that it might not be fractured); a fracture of the sternum at a point which corresponded to the junction of the first and second pieces resulted, the fragments not having been displaced. In other cases, the ligaments binding down the inner extremity of the clavicle might give way, and dislocation upwards ensue. As exemplifying this last result, he showed a specimen from the museum of Guy's Hospital, in which the inner end of the clavicle had been dislocated upwards, and the ossified first costal cartilage was fractured on the same side. Its line of fracture was irregular, and not vertical, as in fracture of the ordinary elastic cartilage. The sternum was not fractured. Mr. Lane showed a specimen similar to one which he had shown at the Society last year. The first cartilages and sternum had sustained the same fractures, no other bones in the body showing any sign of fracture. A case recorded by Dr. Bennett (*Dublin Quarterly Journal*) served also to illustrate his view. A heavy weight fell on a man, fracturing many bones. That which had fallen on the clavicles had fractured both first cartilages and the sternum at the junction of the first and second pieces. He believed that fracture of the sternum or cartilages, or of both, was not so very uncommon as the scanty literature on the subject would suggest; also that Maisonneuve had no clear idea how the clavicle transmitted force to the sternum, which it did only indirectly by pressure on the first rib and cartilage. M. Maisonneuve apparently arrived at this conclusion by observing the frequent concomitance of fracture of the scapula and clavicle with that of the sternum. The sternum and cartilages, when fractured by this means, would present very little sign during life, or at a period long after the injury, owing to the fractures remaining in apposition. It was very difficult to decide, in many ossified first cartilages, whether they had been fractured or not, as they frequently presented a very irregular outline, owing to abundant deposit of new bone, which might either be the result of fracture, or thrown up to support the joint formed in this situation.—*Brit. Med. Journ.*, March 8, 1884.

Suture of the Olecranon for Simple Fracture.

Mr. W. P. Keall reports the case of a man, æt. 33 years, who had sustained a simple fracture of the olecranon, caused by a blow with a heavy iron bar, inflicted on the arm which was raised to protect his head. The fragments were separated more than an inch when the arm was straightened.

On the next day an incision about four inches long was made from the tip of the olecranon downwards, over the posterior aspect of the ulna, similar to the lower part of the incision for excision of the elbow-joint. The soft parts were cleared away for a small space from the posterior surface of the fragment, and a hole drilled through to the broken surface, avoiding the articular cartilage; through this a stout silver wire was passed from the outside inwards. The tissues were then in a like manner separated from the ulna, and another hole drilled in the same way, except that from the angle made by the two surfaces. The direction of this one had to be made more obliquely than the first; and in this he was more fortunate than Sir Joseph Lister was in the cases he describes, and of which he gives a wood-cut in the *British Medical Journal* for November 3d, 1883, therefore there was no need to adopt the very ingenious manœuvre carried out by him with the needle and gouge.

The joint, of which the articular cartilage, especially that covering the surface of the humerus, was plainly visible, was cleared of blood-clot and *débris* from the drilling of the bone; another wire was passed through this from without inwards, and the end of it between the two fragments of bone was passed through a loop formed at the internal end of the first wire, by which it was pulled out through the first hole. The two pieces of bone then being well pressed together, the two ends of the wire were drawn tight, twisted together, cut off, bent and hammered down on to and partially into the bone. A drainage tube having been inserted, the wound was stitched up and dressed with the protective and gauze in the usual manner.

The patient steadily improved, and in four weeks he could bend the joint to a right angle. In six weeks most of the movements of the elbow were almost perfect. He could extend it until almost straight, bend it to less than a right angle, could touch his head, and could pronate and supinate, and seven weeks after the operation he resumed his work.—*Bristol Medico-Chirurg. Journ.*, March, 1884.